PRIMARY HEALTH-CARE REFORM PROGRAM: SALTA, LA PAMPA, AND CÓRDOBA

(AR-0120)

EXECUTIVE SUMMARY

Borrower and guarantor:	Argentine Republic	
Executing agency:	Ministry of Health and Welfare (MSAS)	
Amount and source:	IDB	US$100 million: (OC)
	Local:	US$ 67 million
	Total:	US$167 million
Financial terms and conditions:	Amortization period:	20 years
	Grace period:	5 years
	Disbursement period:	5 years
	Interest rate:	variable
	Inspection and supervision:	1%
	Credit fee:	0.75%
	Currency:	U.S. dollars, Single Currency Facility
Objectives:	Support the Argentine government's efforts to make for more efficient and equitable health-care delivery, introducing new primary health-care approaches in the selected provinces with a view to: (a) ensuring that health services reach the neediest, using specific targeting criteria; (b) moving from the current government-sponsored care-delivery systems to systems driven largely by user needs and preferences; (c) gradually replacing the fixed-salary system with fee-for-service arrangements, promoting financial incentives to reward quality care-providers; and (d) adopting family health-care approaches and more cost-effective health-care management models.	

Description: The program is divided into three components:

1. National component (US$22.3 million)

The aims of this component are to: (i) retrain health workers and devise basic primary health-care (PHC) training strategies for Family Health Teams in the provinces, adapting formal health-education systems and instruments; (ii) adjust the MSAS structure to the new model, particularly in the areas of information systems, public information programs, and institution-strengthening for implementation and monitoring of the new model; and (iii) provide funding and technical support for the design of PHC reform projects that the provinces request, for consideration in an eventual new operation. This national component is subdivided into three subcomponents:

a. Human resources training, retraining, and realignment (US$15.2 million): This subcomponent covers human resources retraining and the development of strategies to build PHC contents into all health-worker training and development processes, such as short-term training, undergraduate programs, PHC residencies, graduate studies, and continuing education. The main activities planned are: (i) support for the design of professional PHC training plans in the provinces; (ii) short-term PHC training, including the management systems area; (iii) devising Family Health Team professional profiles and certification and recertification mechanisms; (iv) rewriting the curricula of undergraduate training programs for doctors and other health professionals, to gear them to PHC and family medicine; (v) creation of PHC residencies for doctors and nurses at universities and training centers for health professionals; and (vi) development of continuing education PHC programs and instruments for Family Health Teams (graduate courses, distance education, rotation systems).

b. Adapting the MSAS structure involved in the new PHC model (US$3.3 million): The three activities comprising this subcomponent are: (i) a PHC information system; (ii) a public information program; and (iii) institution-strengthening of the MSAS.

c. Preparation of provincial projects (US$3.8 million): The MSAS will provide resources to prepare provincial projects, based on: (i) the province's request for the project and its undertaking to observe the principles of PHC reform; (ii) a

verification of conditions for the provincial project's implementation (situational diagnosis); (iii) a preparatory action plan for the project's implementation; (iv) selection of a consulting firm, in accordance with international competition requirements, to prepare the project; and (v) development of the project following the pre-established methodology.

2. Primary health-care reform in the province of Salta (US$35.8 million)

The object of this component is to implement PHC reform in the province of Salta. The project's central aims are to create Family Health Units built around new personnel compensation and incentive systems, adapt physical plant, bring in personnel training strategies with MSAS support, and strengthen the ministry institutionally for the tasks of regulating, managing, and evaluating the new model. The component is divided into five subcomponents:

a. Remuneration and incentive system (US$12.5 million): The focal point of this human-resources realignment will be an incentive system whereby provincial public-sector health workers will come under a new contractual, compensation and personnel management system. The aim is to gradually shift from the current fixed-salary system to a capitation-payment approach in which Family Health Teams will see their remuneration (which will depend on user preferences) tied to per capita income in urban areas and incentives for productivity, quality, and coverage in peri-urban and rural areas.

   The program will fund capitation payments for Family Health Teams who serve the program's target populations. These payments will be gradually phased out, to be progressively absorbed into the provincial health budget. Capitation payments for other client bases will be covered by the *Obras Sociales* employee-benefit plans, prepaid health-care plans, or directly by higher-income families. Capitation fees will be risk-adjusted for such factors as sex and age. The public and private sector and the *Obras Sociales* plans all may set up Family Health Units, following the organization model established by the program.

b. Infrastructure adaptation (US$10.2 million): This subcomponent will finance the repair, remodeling, and re-

equipping of government-run PHC plant, as required for each facility, with special emphasis on family medicine clinics and their equipment, and improvements in the referral network for PHC patients requiring more advanced treatment.

c. Information systems (US$4.7 million). This subcomponent will implement a user identification and registration system, apply mechanisms to target the program to low-income groups, produce morbidity and cost data to set up cost-recovery systems, institute quality monitoring and management services, and strengthen the provincial Health Ministry's information management capacity. Though the system will be free only for low-income clients (via targeting), the user identification system will take in the entire province. The new system will operate as a gateway to all levels of health care.

Health-service users will be identified through a system of magnetic health cards containing information on: (a) their socioeconomic status and (b) health plans to which they belong (*Obras Sociales,* prepaid health-care organizations, etc.). Once the PHC system is automated, a database of epidemiological data and health-services utilization can be constructed.

d. Public information (US$4.8 million): This subcomponent will finance strategies to communicate and publicize the new family-health model to stakeholders such as doctors and other health professionals, professional associations, universities, health-care providers and managers, Obras Sociales plans, and prepaid health-care organizations and clients of these services.

e. Institution-strengthening (US$3.6 million): Under this subcomponent, the provincial Health Ministry will commission studies and consulting services to map out the basic management structure for the new system's operation, administration, and monitoring.

3. Primary health-care reform in the provinces of La Pampa and Córdoba (US$101.5 million)

The La Pampa provincial government informed the MSAS of its interest in participating in the program, and developed its own project proposal to submit to the MSAS and the Bank for consideration. Though by virtue of that effort the province would

qualify for the program, the project design it presented was viewed as preliminary. The Province of La Pampa will develop its project following the methodology used to prepare the Province of Salta's project; the cost of preparing the La Pampa project will be defrayed with preinvestment funds (loan 925/OC-AR).

The new government of the Province of Córdoba informed the MSAS of its intention to join the program. At present, to qualify, it is working toward a preliminary project proposal to be presented shortly, following the Operating Regulations guidelines. Preinvestment funds under loan 925/OC-AR will be used to prepare this project as well.

Relationship of project in Bank's country and sector strategy:

In keeping with the national government's stated priorities and with Eighth Replenishment guidelines, the Bank is focusing on the following areas in its operations with Argentina: (i) deepen and consolidate modernization of the State at the central level and extend the process to provincial and municipal governments; (ii) reduce poverty and raise the standard of living through actions designed to create productive employment and broaden the coverage of social programs; and (iii) increase productivity and competition in the tradable-goods sectors with environmentally friendly approaches, providing support infrastructure and activities to help modernize the production apparatus and advance regional integration. The proposed program would address the first two of these objectives.

Environmental and social review:

To maximize the program's impact on its various target populations, the public information, infrastructure adaptation, and personnel training and realignment components include health strategies for women and aboriginal peoples. The Operating Regulations contain environmental protection measures to ensure that physical investments (first level) are environmentally viable. These environmental and social considerations will apply for the Province of Salta project. No environmental impact assessment was required in preparing the program (see paragraph 4.22).

Benefits:

Notable benefits of this program will be: (a) improved health of the population once primary-care coverage is broadened and targeted to low-income groups and the most vulnerable, like women and children; (b) more effective care delivery, by way of a guaranteed basket of core services; (c) better-quality care and greater patient satisfaction as competition mechanisms are introduced and people are able to choose their family doctor; (d) more efficient health care, as health personnel costs are

adjusted in the medium and long term and more flexible contracting systems are brought in; (e) a more equitable health-care system, when the costs of care delivered to members of *Obras Sociales* and prepaid health-care plans are recovered, whereupon public funds can be spent on those most in need; and (f) configuration of the health-care network coordinated with reforms under way in the country.

Risks:

a. Coordination with other reform projects: To be successful, the program described here must dovetail closely with other ongoing health-reform projects such as the World Bank-funded Autonomous Public Hospitals Program (PRESSAL), Maternal and Child Nutrition Program (PROMIN), and *Obras Sociales* Reform Program (PROS). To help assure such coordination, a preliminary arrangement has been worked out with the MSAS to adjust the PROMIN so it can help establish a demand-driven care system. The MSAS is coordinating with the PRESSAL and the *Obras Sociales* program to this same end.

b. Interest groups' acceptance of the model: The change in employment status that government health workers would undergo in the proposed program could move interest groups to resist the reforms. To counter this eventuality, the program offers financial incentives to win its acceptance and public information strategies to explain its merits and thereby reduce resistance to the changes.

c. Lack of coordination between training activities and implementation of the model: The project will require close coordination between the training tasks planned in the national component and personnel training needs in the provinces. To avert problems in this area, the program's central executing unit (CEU) and provincial executing units will together come up with a program evaluation and review (PERT) graph to sequence the joint, coordinated activities needed for PHC personnel training and realignment in each provincial project.

Special contractual clauses:

The following would be contractual conditions precedent to the first disbursement: (i) set-up of the CEU within the MSAS, duly organized and staffed, and (ii) entry into force, by MSAS order, of the program's Operating Regulations, previously agreed upon with the Bank (paragraph 3.3).

Special conditions precedent to the first disbursement of funds for the Salta, La Pampa, and Córdoba projects are: (i) signing by the borrower and the respective province of a subsidiary loan contract, by authority of a provincial borrowing law authorizing the provincial executing agency to take on the loan according to the terms and conditions of the proposed Bank loan contract (paragraph 3.42); (ii) set-up of a provincial executing unit within each participating provincial Health Ministry, duly organized and staffed (paragraph 3.27); (iii) entry into force of the program's Operating Regulations; and (iv) demonstration that the register of the target provincial population has been at least two-thirds completed by the Master System for Identification and Registration of Social Program Beneficiary Households (SISFAM) (paragraph 3.19).

The following are additional special conditions for the program's implementation: (i) the first disbursement of resources for the training subcomponent for each province will be conditioned upon presentation of the province's human resources training and reconversion strategy (paragraph 3.6); (ii) the first disbursement for activities to realign undergraduate medical, nursing, and other health professional programs to a PHC approach will not be released until the MSAS has prepared, to the Bank's satisfaction, profiles and protocols for health-worker certification, which would be financed in advance by the program (paragraph 3.12); (iii) for the model to operate, the provincial Health Ministries must sign management contracts with Family Health Teams and Family Health Units for health-care management; the model contract must have received the Bank's no objection (paragraph 3.38); and (iv) to institute the program monitoring mechanism, the contract will contain conditions governing the scheduling of monitoring and evaluation activities, as agreed with the borrower (paragraphs 3.49 to 3.51).

Poverty-targeting and social sector classification:

The proposed project classifies as an operation promoting social equity, as described in the key objectives for the Bank's activities in the Report on the Eighth General Increase in Resources. It also qualifies as a poverty-targeted investment (PTI) (see paragraph 4.32). The borrower will use the additional 10% financing (see paragraph 4.32). The project specifies explicit performance

benchmarks to measure poverty reduction and improvements in social equity. The operation classifies automatically as a PTI by virtue of the sector it addresses, as a primary health-care program targeted mainly to low-income families.

Exceptions to Bank policy: None.

Procurement: International competitive bidding is recommended for: (i) construction tenders worth over US$5 million, (ii) goods for adaptation of the health units and for institution-strengthening costing over US$350,000, and (iii) consulting-firm contracts over US$200,000.